

Notice of Intent to Return From FMLA Leave/Simple Certification of Fitness For Duty

Name: _____

Supervisor: _____

Date leave commenced: _____

Date of planned return: _____

I understand that my restoration to employment is subject to the following conditions:

1. If leave was for a continuous block of time and my health care provider has released me to return to work, I intend to return to work as scheduled. If no, I am stating I do not intend to return to work and I am resigning my employment with Metro.

___ Yes ___ No

2. I was advised, prior to the date of this Notice, that as a condition of restoration, I would be required to provide a written certification from my health care provider that I am able to resume working and can perform the essential functions of my job. My health care provider has reviewed documents related my job and their certification is indicated below.

Employee's signature

Date

Health Care Provider Information:

I have examined (employee name) and can certify that she/he is fully able to resume working.

Health care provider's signature

Date

Printed name: _____

NOTE: keep copy of letter in departmental personnel file and send a copy to Human Resources – Benefit Services, 222 3rd Avenue North, Suite 200, Nashville, TN 37201

